Government of the District of Columbia
Department of Health
Health Professional Licensing Administration

SUPERVISION FORM

DIRECTIONS TO THE APPLICANT

Complete the following information. If additional forms are required, make duplicates of this form. After your supervisor has completed his/her portion of this form, it must be returned to you and included in your application package.

Name of Applicant (please print) _____

DIRECTIONS TO THE SUPERVISOR

This form should be completed in ink and returned to the applicant for inclusion with his/her application form. ALL items must be filled in or the applicant's application will not qualify.

I, _____, certify that I supervised
(supervisor)

_____ in the practice of professional counseling
(applicant)

at _____
(agency or organization)

from ____/____/_____ to ____/____/_____
(date) (date)

This applicant worked a minimum of _____ hours per week at the above agency for the stated time period.

I provided a total of _____ hours of general supervision.

I provided a total of _____ hours of immediate supervision.

Title of Applicant's position: _____

Applicant's duties and responsibilities: _____

_____

_____

Was the applicant's performance satisfactory or better? Yes (___) No (___)

I certify that I provided the supervision described above and that it is a true and accurate representation of this supervision.

THE BOARD ASSUMES THAT YOU, IN CERTIFYING THIS APPLICANT'S EXPERIENCE, ARE WILLING TO INTEREST OR SUBSTANTIATE THE INFORMATION PROVIDED SHOULD THE BOARD NEED CLARIFICATION AT A LATER DATE.

_____ _____ _____
Signature of Supervisor Date Address of Agency/Organization

_____ _____ _____ _____
Address of Supervisor City/State/Zip Code Telephone Number